share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.myhnas.com or call The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would

underlined terms see the Glossary. You can view the Glossary at www.myhnas.com or call 1-877-356-0666 to request a copy. 1-877-356-0666. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other

Important Ougetions	Appropri	With This Matters:
infortant gassions	2.2	
What is the overall deductible?	For in-network <u>providers</u> \$1,000/person and \$2,000/family. For out-of-network <u>providers</u> \$3,000/person and \$9,000/family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes, preventive care expenses.	This <u>plan</u> covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-carebenefits/.
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-</u> pocket limit for this <u>plan?</u>	For in-network providers \$4,000/person and \$8,000/family. For out-of-network providers \$7,500/person and \$22,500/family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Prescription drug copayments, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network</u> provider?	Yes. See www.blueshieldca.com/NetworkPPO or call 1-800-810-2583 for a list of network providers.	This <u>plan</u> uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware that your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

		If you need immediate	No. of Contract of	-	If you have outpatient		If you have a test	AND SECULO SECUL		If you visit a health	TO SERVICE AND ADDRESS OF THE PARTY OF THE P		Common Medical Event
Urgent care	Emergency medical transportation	Emergency room care – non-emergent use	Emergency room care – emergent use	Physician/surgeon fees	Facility fee (e.g., ambulatory surgery center)	Imaging (CT/PET scans, MRIs)	Diagnostic test (x-ray, blood work)	Preventive care/screening/ immunization	Chiropractic visit	Teladoc consultation	Specialist visit	Primary care visit to treat an injury or illness	Services You May Need
\$15/visit. <u>Deductible</u> does not apply.	10% coinsurance*	40% coinsurance*	10% coinsurance after \$75/visit. Deductible does not apply.	10% coinsurance*	10% coinsurance*	10% coinsurance*	10% coinsurance*	No charge. <u>Deductible</u> does not apply.	10% coinsurance* after \$15/visit	\$5 copay. <u>Deductible</u> does not apply.	\$15/visit. Deductible does not apply.	\$15/visit. Deductible does not apply.	What Y In-Network Provider (You will pay the least)
40% coinsurance*	10% coinsurance*	40% coinsurance*	10% coinsurance after \$75/visit. Deductible does not apply.	40% coinsurance*	40% coinsurance*	40% coinsurance*	40% coinsurance*	40% coinsurance*	Not covered	Not covered	40% coinsurance*	40% coinsurance*	What You Will Pay vider Out-of-Network Provider least) (You will pay the most)
None	None	None	Copay waived if admitted.	Precertification required on select procedures.**	None	Precertification required on select procedures.**	None	Includes preventive services as mandated by ACA. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.	Limited to 20 visits/year.	None	None	None	Limitations, Exceptions, & Other Important Information

Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	what You Will Pay vider	Limitations, Exceptions, & Other Important Information
If you have a hospital	Facility fee (e.g., hospital room)	10% coinsurance* after \$100/admit	40% coinsurance*	Precertification required.**
stay	Physician/surgeon fees	10% coinsurance*	40% coinsurance*	None
If you need mental health, behavioral	Outpatient services	\$15/visit. Deductible does not apply.	40% coinsurance*	Certain behavioral health services are not covered.
health, or substance abuse services	Inpatient services	10% coinsurance* after \$100/admit	40% coinsurance*	Precertification required.** Certain behavioral health services are not covered.
	Office visits	No charge. <u>Deductible</u> does not apply.	40% coinsurance*	Cost-sharing does not apply for in-network routine prenatal services that are considered preventive care.
If you are pregnant	Childbirth/delivery professional services	10% coinsurance*	40% coinsurance*	None
	Childbirth/delivery facility services	10% coinsurance* after \$100/admit	40% coinsurance*	None
Name of the State	Home health care	10% coinsurance*	40% coinsurance*	Precertification required for out-of-network services.** Limited to 100 visits/year.
If you need help	Rehabilitation services - physical, speech, occupational, and other rehabilitative therapies	10% <u>coinsurance</u> * after \$15/visit	40% coinsurance*	Precertification required for speech therapy.** Limited to an aggregated 60 in-network visits/year and 30 out-of-network visits/year.
recovering or nave	Habilitation services	Not covered	Not covered	None
needs	Skilled nursing care	10% coinsurance*	40% coinsurance*	Precertification required.** Limited to 100 consecutive days/year in-network; 60 consecutive days/year out-of-network.
	Durable medical equipment	10% coinsurance*	40% coinsurance*	Precertification required on select items.**
	Hospice services	10% coinsurance*	40% coinsurance*	Precertification required for inpatient care.** Limited to 180 days/lifetime.
If wour child poods	Children's eye exam	Not covered	Not covered	None
dental or eve care	Children's glasses	Not covered	Not covered	None
delital of election	Children's dental check-up	Not covered	Not covered	None
* Doductible applies				

Deductible applies.

Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. Failure to precertify out-of-network services will result in a 50% penalty.

	More information about prescription drug coverage is available at www.usscript.com	If you need drugs to treat your illness or condition			Medical Event	Common
Non-preferred brand drugs	Preferred brand drugs	Generic drugs	Family maximum out-of- pocket amount	Individual maximum out-of- pocket amount	Services You May Need	
\$40/prescription	\$25/prescription	\$15/prescription	↔	↔	Retail Pharmacy (34 day supply)	What Y
\$80/prescription	\$50/prescription	\$30/prescription	\$4,000	\$2,000	Mail Order Pharmacy (90 day supply)	What You Will Pay
available, the covered person must pay the difference between the cost of the preferred or non-preferred brand name drug and the generic equivalent, plus the generic co-pay unless the physician specifies "Dispense as Written".	The Prescription Drug Plan will pay up to the generic price, less the generic co-pay, whenever a generic drug is dispensed. If a preferred or non-preferred brand name drug is dispensed, and a generic equivalent is	Certain medications considered <u>preventive</u> <u>care</u> under ACA are payable at no cost-share to the member.	services. This limit helps you plan for health care expenses.	The out-of-pocket limit is the most you could pay during a coverage period (usually one	Information	Limitations Exceptions & Other Important

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids

- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the
- Private duty nursing
- Routine eye care (adult)
- Routine foot care
 Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Bariatric surgery

Chiropractic care

agencies is: HealthNow Administrative Services, 1-877-356-0666, www.myhnas.com; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those

contact: Department of Labor/Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a

Does this plan provide Minimum Essential Coverage? Yes

requirement that you have health coverage for that month If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-356-0666.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-356-0666

Chinese (中文): 如果需要中文的帮助,**请拨打这个号码1-877-356-0666**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-356-0666

-To see examples of how this plan might cover costs for a sample medical situation, see the next section.-



amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage. This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a wellcontrolled condition)

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

Other coinsurance Hospital (facility) coinsurance

Specialist copayment

The plan's overall deductible

\$1000

\$15 10% 10%

Other coinsurance

The plan's overall deductible Specialist copayment Hospital (facility) coinsurance \$1000 \$15 10%

Specialist copayment The plan's overall deductible

\$1000

Specialist office visits (prenatal care, This EXAMPLE event includes services like:

Specialist visit (anesthesia) Diagnostic tests (ultrasounds and blood work) Childbirth/Delivery Facility Services Childbirth/Delivery Professional Services

rimary	his EX
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imary care physician office visits (including	his EXAMPLE event includes services like:
n office	nt inclu
visits (des se
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disease education)

Diagnostic tests (blood work) Prescription drugs

Durable medical equipment (glucose meter)

7	This
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	This EXAMPLE event includes services like:
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Other coinsurance

Hospital (facility) coinsurance

10% \$15

supplies) Emergency room care (including medical

Diagnostic test (x-ray)

Rehabilitation services (physical therapy, Durable medical equipment (crutches)

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4.7,700	\$40 700
412,100	\$40 700

In this example, Peg would pay:

Cost Sharing

Total Example Cost

In this example, Joe would pay:

\$1500	The total Joe would pay is
\$60	Limits or exclusions
10000	What isn't covered
\$0	Coinsurance
\$1310	Copayments
\$130	Deductibles
	Cost Sharing

\$1050

\$140

\$1000

The total Peg would pay is

\$2250

\$60

Limits or exclusions

What isn't covered

Coinsurance Copayments Deductibles

Total Example Cost \$1,900

\$7,400

In this example, Mia would pay:

The total Mia would pay is	Limits or exclusions	What isn't covered	Coinsurance	Copayments	Deductibles	Cost Sharing
\$990	\$0		\$70	\$110	\$810	

share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.myhnas.com or call The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would

underlined terms see the Glossary. You can view the Glossary at www.myhnas.com or call 1-877-356-0666 to request a copy. 1-877-356-0666. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other

Important Questions What is the overall deductible? Are there services	Answers For in-network <u>providers</u> \$500/person and \$1,000/family. For out-of-network <u>providers</u> \$1,500/person and \$4,500/family.	Why This Matters: Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . This <u>plan</u> covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain
Are there services covered before you meet your deductible? Are there other deductibles for specific services?	Yes, preventive care expenses.	This <u>plan</u> covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-carebenefits/. You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-</u> pocket limit for this plan?	For in-network <u>providers</u> \$3,500/person and \$7,000/family. For out-of-network <u>providers</u> \$6,000/person and \$18,000 /family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Prescription drug copayments, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network</u> <u>provider</u> ?	Yes. See www.blueshieldca.com/NetworkPPO or call 1-800-810-2583 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware that your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

		If you need immediate		surgery	If you have outpatient	ii Jou liave a test			care <u>provider's</u> office or clinic	If you visit a health		Service Control	Medical Event	
Urgent care	Emergency medical transportation	Emergency room care – non-emergent use	Emergency room care – emergent use	Physician/surgeon fees	Facility fee (e.g., ambulatory surgery center)	Imaging (CT/PET scans, MRIs)	Diagnostic test (x-ray, blood work)	Preventive care/screening/ immunization	Chiropractic visit	Teladoc consultation	Specialist visit	Primary care visit to treat an injury or illness	Services You May Need	
\$15/visit. <u>Deductible</u> does not apply.	10% coinsurance*	40% coinsurance*	10% coinsurance after \$75/visit. Deductible does not apply.	10% coinsurance*	10% coinsurance*	10% coinsurance*	10% coinsurance*	No charge. <u>Deductible</u> does not apply.	10% <u>coinsurance</u> * after \$15/visit	\$5 copay. <u>Deductible</u> does not apply.	\$15/visit. <u>Deductible</u> does not apply.	\$15/visit. <u>Deductible</u> does not apply.	In-Network Provider (You will pay the least)	What Y
40% coinsurance*	10% coinsurance*	40% coinsurance*	10% <u>coinsurance</u> after \$75/visit. <u>Deductible</u> does not apply.	40% coinsurance*	40% coinsurance*	40% coinsurance*	40% coinsurance*	40% coinsurance*	Not covered	Not covered	40% coinsurance*	40% coinsurance*	Out-of-Network Provider (You will pay the most)	What You Will Pay
None	None	None	Copay waived if admitted,	Precertification required on select procedures.**	None	Precertification required on select procedures.**	None	Includes preventive services as mandated by ACA. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.	Limited to 20 visits/year.	None	None	None	Limitations, Exceptions, & Other Important Information	

delital of eye care	dental or eve care	H vour child pands	4		needs	other special health	If you need help			If you are pregnant		health, or substance abuse services	If you need mental health, behavioral	stay	If you have a hospital	Medical Event	Common
Children's dental check-up	Children's glasses	Children's eye exam	Hospice services	Durable medical equipment	Skilled nursing care	Habilitation services	Rehabilitation services - physical, speech, occupational, and other rehabilitative therapies			Childbirth/delivery professional services	Office visits	Inpatient services	Outpatient services	Physician/surgeon fees	Facility fee (e.g., hospital room)	Services You May Need	
Not covered	Not covered	Not covered	10% coinsurance*	10% coinsurance*	10% coinsurance*	Not covered	10% <u>coinsurance</u> * after \$15/visit	10% coinsurance*	10% <u>coinsurance</u> * after \$100/admit	10% coinsurance*	No charge. <u>Deductible</u> does not apply.	10% coinsurance* after \$100/admit	\$15/visit. <u>Deductible</u> does not apply.	10% coinsurance*	10% coinsurance* after \$100/admit	In-Network Provider (You will pay the least)	What Y
Not covered	Not covered	Not covered	40% coinsurance*	40% coinsurance*	40% coinsurance*	Not covered	40% coinsurance*	40% coinsurance*	40% coinsurance*	40% coinsurance*	40% coinsurance*	40% coinsurance*	40% coinsurance*	40% coinsurance*	40% coinsurance*	Out-of-Network Provider (You will pay the most)	What You Will Pay
None	None	None	Precertification required for inpatient care.** Limited to 180 days/lifetime.	Precertification required on select items.**	Precertification required.** Limited to 100 consecutive days/year in-network; 60 consecutive days/year out-of-network.	None	Precertification required for speech therapy.** Limited to an aggregated 60 in-network visits/year and 30 out-of-network visits/year.	Precertification required for out-of-network services.** Limited to 100 visits/year.	None	None	Cost-sharing does not apply for in-network routine prenatal services that are considered preventive care.	Precertification required.** Certain behavioral health services are not covered.	Certain behavioral health services are not covered.	None	Precertification required.**	Information	Limitations, Exceptions, & Other Important

Deductible applies.

Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. Failure to precertify out-of-network services will result in a 50% penalty.

Content Admin	More information about prescription drug coverage is available at www.usscript.com	If you need drugs to treat your illness or condition			Medical Event	Common
Non-preferred brand drugs	Preferred brand drugs	Generic drugs	Family maximum out-of- pocket amount	Individual maximum out-of- pocket amount	Services fou May Need	
\$40/prescription	\$25/prescription	\$10/prescription	ę,	\$	(34 day supply)	What Y
\$80/prescription	\$50/prescription	\$20/prescription	\$4,000	\$2,000	Mail Order Pharmacy (90 day supply)	What You Will Pay
available, the covered person must pay the difference between the cost of the preferred or non-preferred brand name drug and the generic equivalent, plus the generic co-pay unless the <i>physician</i> specifies "Dispense as Written".	The Prescription Drug Plan will pay up to the generic price, less the generic co-pay, whenever a generic drug is dispensed. If a preferred or non-preferred brand name drug is dispensed, and a generic equivalent is	Certain medications considered <u>preventive</u> <u>care</u> under ACA are payable at no cost-share to the member.	services. This limit helps you plan for health care expenses.	The out-of-pocket limit is the most you could pay during a coverage period (usually one	Information	Limitations, Exceptions, & Other Important

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids

- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the
- Private duty nursing
- Routine eye care (adult)
 Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Bariatric surgery

Chiropractic care

agencies is: HealthNow Administrative Services, 1-877-356-0666, www.myhnas.com; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

contact: Department of Labor/Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a

Does this plan provide Minimum Essential Coverage? Yes

requirement that you have health coverage for that month If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace

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Chinese (中文): 如果需要中文的帮助,**请拨打这个号码1-877-356-0666**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-356-0666.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage. This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be

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(9 months of in-network pre-natal care and a hospital delivery)

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well controlled condition)

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

	Other coinsurance	Hospital (facility) coinsurance	Specialist copayment
•	10%	10%	\$15

Other coinsurance

The plan's overall deductible

\$500

■ The plan's overall deductible Specialist copayment Hospital (facility) coinsurance \$500 \$15 10%

Hospital (facility) coinsurance Specialist copayment The plan's overall deductible \$500 10% \$15

This EXAMPLE event includes services like:

Specialist visit (anesthesia) Diagnostic tests (ultrasounds and blood work) Childbirth/Delivery Facility Services Childbirth/Delivery Professional Services Specialist office visits (prenatal care,

This EXAMPLE event includes services like:

disease education) Prescription drugs Primary care physician office visits (including Diagnostic tests (blood work)

This EXAMPLE event includes services like:

Other coinsurance

supplies, Emergency room care (including medical Diagnostic test (x-ray)

Total Example Cost \$7,400 Durable medical equipment (glucose meter)

Total Example Cost

Rehabilitation services (physical therapy) Durable medical equipment (crutches)

In this example, Peg would pay:

Total Example Cost

\$12,700

The total Peg would pay is	Limits or exclusions	What isn't covered	Coinsurance	Copayments	Deductibles	Cost Snanng
\$1790	\$60		\$1100	\$130	\$500	

In this example, Joe would pay:

The total Joe would pay is	Limits or exclusions	What isn't covered	Coinsurance	Copayments	Deductibles	Cost Sharing	overbiol and month bay.
\$1290	\$60	1000	\$0	\$1100	\$130		

In this example, Mia would pay:

\$740	The total Mia would pay is
\$0	Limits or exclusions
	What isn't covered
\$90	Coinsurance
\$150	Copayments
\$500	Deductibles
	Cost Sharing

share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.myhnas.com or call The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would

underlined terms see the Glossary. You can view the Glossary at www.myhnas.com or call 1-877-356-0666 to request a copy. 1-877-356-0666. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other

Important Questions	Answers For in-network providers \$0/person and	Why This Matters: Generally, you must pay all of the costs from providers up to the deductible amount before
What is the overall deductible?	For in-network <u>providers</u> \$0/person and \$0/family. For out-of-network <u>providers</u> \$200/person and \$600/family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes, preventive care expenses.	This <u>plan</u> covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-carebenefits/.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-</u> <u>pocket limit</u> for this <u>plan?</u>	For in-network <u>providers</u> \$3,000/person and \$6,000/family. For out-of-network <u>providers</u> \$4,700/person and \$14,100 /family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Prescription drug copayments, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network</u> <u>provider?</u>	Yes. See www.blueshieldca.com/NetworkPPO or call 1-800-810-2583 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware that your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider before</u> you get services.
Do you need a <u>referral</u> to see a <u>specialist?</u>	No.	You can see the specialist you choose without a referral.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

stay F	If you have a hospital	Ĺ		If you need immediate E	o Im	surgery F	If you have outpatient s	n you nave a test		or clinic	vider's office		Iro		Medical Event	
Physician/surgeon fees	Facility fee (e.g., hospital room)	Urgent care	Emergency medical transportation	Emergency room care – non-emergent use	Emergency room care – emergent use	Physician/surgeon fees	Facility fee (e.g., ambulatory surgery center)	Imaging (CT/PET scans, MRIs)	Diagnostic test (x-ray, blood work)	Preventive care/screening/ immunization	Chiropractic visit	Teladoc consultation	Specialist visit	Primary care visit to treat an injury or illness	Services You May Need	
15% coinsurance	15% <u>coinsurance</u> after \$100/admit	\$15/visit	15% coinsurance	30% coinsurance	15% <u>coinsurance</u> after \$75/visit	15% coinsurance	15% coinsurance	15% coinsurance	15% coinsurance	No charge	15% <u>coinsurance</u> after \$15/visit	\$5 copay	\$15/visit	\$15/visit	In-Network Provider (You will pay the least)	What Y
30% coinsurance*	30% coinsurance*	30% coinsurance*	Paid as in-network	30% coinsurance*	Paid as in-network	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*	Not covered	Not covered	30% coinsurance*	30% coinsurance*	Out-of-Network Provider (You will pay the most)	What You Will Pay
None	Precertification required.**	None	None	None	Copay waived if admitted.	Precertification required on select procedures.**	None	Precertification required on select procedures.**	None	Includes preventive services as mandated by ACA. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.	Limited to 20 visits/year.	None	None	None	Information Information	

aciliar of old one	dental or eve care	If your child peads	If you need help recovering or have other special health needs					If you are pregnant If you need help recovering or have other special health needs				health, or substance abuse services	If you need mental health, behavioral	Common Medical Event
Children's dental check-up	Children's glasses	Children's eye exam	Hospice services	Durable medical equipment	Skilled nursing care	Habilitation services	Rehabilitation services - physical, speech, occupational, and other rehabilitative therapies	Home health care	Childbirth/delivery facility services	Childbirth/delivery professional services	Office visits	Inpatient services	Outpatient services	Services You May Need
Not covered	Not covered	Not covered	15% coinsurance	15% coinsurance	15% coinsurance	Not covered	15% <u>coinsurance</u> after \$15/visit	15% coinsurance	15% <u>coinsurance</u> after \$100/admit	15% coinsurance	No charge	15% <u>coinsurance</u> after \$100/admit	\$15/visit	What Y In-Network Provider (You will pay the least)
Not covered	Not covered	Not covered	30% coinsurance*	30% coinsurance*	30% coinsurance*	Not covered	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*	30% coinsurance*	What You Will Pay vider Out-of-Network Provider least) (You will pay the most)
None	None	None	Precertification required for inpatient care.** Limited to 180 days/lifetime.	Precertification required on select items.**	Precertification required.** Limited to 100 consecutive days/year in-network; 60 consecutive days/year out-of-network.	None	Precertification required for speech therapy.** Limited to an aggregated 60 in-network visits/year and 30 out-of-network visits/year.	Precertification required for out-of-network services.** Limited to 100 visits/year.	None	None	Cost-sharing does not apply for in-network routine prenatal services that are considered preventive care.	Precertification required.** Certain behavioral health services are not covered.	Certain behavioral health services are not covered.	Limitations, Exceptions, & Other Important Information

Deductible applies.

^{*} Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. Failure to precertify out-of-network services will result in a 50% penalty.

A CONTRACTOR OF THE PARTY OF TH	More information about prescription drug coverage is available at www.usscript.com	If you need drugs to treat your illness or condition	A State of S	High Superpositions	Common Medical Event
Non-preferred brand drugs	Preferred brand drugs	Generic drugs	Family maximum out-of- pocket amount	Individual maximum out-of- pocket amount	Services You May Need
\$30/prescription	\$15/prescription	\$10/prescription	€	€	What Y Retail Pharmacy (34 day supply)
\$60/prescription	\$30/prescription	\$20/prescription	\$4,000	\$2,000	What You Will Pay acy Mail Order Pharmacy ly) (90 day supply)
available, the covered person must pay the difference between the cost of the preferred or non-preferred brand name drug and the generic equivalent, plus the generic co-pay unless the <i>physician</i> specifies "Dispense as Written".	The Prescription Drug Plan will pay up to the generic price, less the generic co-pay, whenever a generic drug is dispensed. If a preferred or non-preferred brand name drug is dispensed, and a generic equivalent is	Certain medications considered <u>preventive</u> <u>care</u> under ACA are payable at no cost-share to the member.	services. This limit helps you plan for health care expenses.	The out-of-pocket limit is the most you could pay during a coverage period (usually one wear) for your share of the cost of covered	Limitations, Exceptions, & Other Important Information

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Hearing aids

- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the
- Private duty nursing
- Routine eye care (adult)

Routine foot care

Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Bariatric surgery

Chiropractic care

Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596 EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the agencies is: HealthNow Administrative Services, 1-877-356-0666, www.myhnas.com; Department of Labor/Employee Benefits Security Administration, 1-866-444-Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those

contact: Department of Labor/Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a

Does this plan provide Minimum Essential Coverage? Yes

requirement that you have health coverage for that month If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-356-0666.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-356-0666.

Chinese (中文): 如果需要中文的帮助,请拨打这个号码1-877-356-0666.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-356-0666.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.



costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage. amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

(a year of routine in-network care of a well-Managing Joe's type 2 Diabetes controlled condition)

(in-network emergency room visit and follow Mia's Simple Fracture

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Other co	Hospital	
	(facility)	
•	coinsurance	

Other coinsurance	Hospital (facility) coinsurance	Specialist copayment	The <u>plan's</u> overall <u>deductible</u>
15%	15%	\$15	\$0

Specialist copayment	The plan's overall deductible
\$15	\$0

The plan's overall deductible up care)

This EXAMPLE event includes services like:

Specialist visit (anesthesia) Childbirth/Delivery Professional Services Specialist office visits (prenatal care) Diagnostic tests (ultrasounds and blood work) Childbirth/Delivery Facility Services

Other coinsurance

15% 15%

Other coinsurance

Specialist copayment

\$15

15% 15%

Hospital (facility) coinsurance

Hospital (facility) coinsurance

disease education) Fillially care physician office visits (modulity

Prescription drugs Diagnostic tests (blood work)

Durable medical equipment (glucose meter)

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/incl	event includes services like:
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supplies, Emergency room care (including medical

Diagnostic test (x-ray)

Rehabilitation services (physical therapy) Durable medical equipment (crutches)

Total Example Cost

\$12,700

Total Example Cost

\$1910	The total Peg would pay is
\$60	Limits or exclusions
	What isn't covered
\$1720	Coinsurance
\$130	Copayments
\$0	Deductibles
The State of	Cost Sharing
	In this example, Peg would pay:

In this example log would nave

\$1050	The total Joe would pay is
\$60	Limits or exclusions
TO A	What isn't covered
\$20	Coinsurance
\$970	Copayments
\$0	Deductibles
The second	Cost Sharing
	in this example, Joe would pay:

Total Example Cost

\$7,400

In this example, Mia would pay:

\$370	The total Mia would pay is
\$0	Limits or exclusions
	What isn't covered
\$220	Coinsurance
\$150	Copayments
\$0	Deductibles
	Cost Sharing